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No. 94-1187

In The

Supreme Court of the United States

October Term, 1994

JOHN PHILLIP SMITH, M.D.,

Petitioner,

vs.

WILLIAM B. RICKS M.D., *et al.*,

Respondents.

On Petition For Writ Of Certiorari
To The United States Court Of Appeal
For The Ninth Circuit

AMICUS CURIAE BRIEF OF THE UNION OF AMERICAN PHYSICIANS AND DENTISTS IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. In interpreting HCQIA, should the courts consider its common-law background? HCQIA loosely outlines the procedural mechanisms for hearings. Conservative industry professionals crafted suggested guidelines for fair procedure.

2. Is public health best protected by ethical peer review, where every doctor is reviewed under the same standards, with equal participation of each physician in each department? This learning/teaching function of peer review elevates the general quality of care at the hospital. It encourages improvement and discourages mediocrity as well as economic waste.

3. Is unethical peer review an earmark of anti-competitive activity?

4. Is impartial outside evaluation standard procedure when an ethical peer review is conducted?

5. Was it frivolous for Dr. Smith to suggest that the procedures followed in his case should be compared to standard industry practices to assess whether the HCQIA's requirement of fair procedure was met?

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I. INTEREST OF *AMICUS CURIAE*

The Union of American Physicians and Dentists ("UAPD") is an independent nationwide trade union of physicians and dentists. Founded in 1972, UAPD represents the professional interests of its members in all practice settings. UAPD's expressed goals are stated in the preamble to its constitution as follows:

> [T]o provide optimum medical care for the people; to insure quality facilities for the provisions of medical care; to enable doctors to give of themselves, unhindered by extraneous forces, for the welfare of their patients . . . (Union of American Physicians and Dentists. Constitution, Preamble, 1972)

As an organization founded to protect the rights of individuals, UAPD has been active in legislative and judicial matters which concern these vital interests. UAPD has appeared as an *amicus* in selected important cases and as a sponsor of legislation which addresses the professional rights of physicians and the public health interest of their patients, the most recent being our sponsorship of California Business and Professions Code § 809, *et seq.*

UAPD's sponsorship of § 809 was based on its assessment that the terms "fair," "reasonable," and "appropriate" in the HCQIA would require years of expensive litigation to develop a common law of appropriate conduct in peer review, hearings, and appeals. Our prediction was optimistic in light of the *Smith* case. A finding that such grossly unfair conduct as we see in *Smith* not only merits qualified immunity under HCQIA but that Dr. Smith was "frivolous" to have contested effective monopolization efforts over heart catheterization in San Jose is a major setback to ethical peer review and a threat to public health.

II. SUMMARY OF FACTS INCLUDING INFORMATION THIS *AMICUS* CAN ADD

A. The Public Health Need for Fair Peer Review Methodology

The facts of an abusive peer review, hearing, and appeal are set-out in detail in Appendix F to the Petition for Certiorari at pages 50a to 56a. They present a case of multi-faceted departures from fair procedure that is commonly expected and usually provided in similar matters.

UAPD is especially concerned about Dr. Smith's documented claim that as to the review he was denied participation in the customary departmental self-examination which is the bedrock of fair peer review.[1] In each hospital, in every department review of each doctor's work by the entire membership of the department is a learning/teaching function of continuing education as well as a control on unnecessary procedures and work that falls below acceptable levels. As Jerome Lackner, MD (the former Secretary of Health for the State of California) has pointed out (E.R. 262), the self-regulating value of these reviews inures to the public benefit, and departures from the usual fully shared peer review practice exposes the public to harm which is not easily addressed – excessive treatment and low quality treatment which does not quite call for sanctions. This court is well aware of the subtle pressure by controlling groups to obtain benefits based upon their coercive power which was exposed in *Summit Health v. Pinhas*, 500 U.S. 322, 111 S.Ct. 1842 (1991) where the controlling group's enrichment machine is reported in terms of kickbacks and unneeded charges all of which are passed on to the public with no corresponding benefit.

The parties and the Court of Appeals failed to highlight the public health need for fair peer review methodology, but that is a driving force behind enactment of the HCQIA. UAPD

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[1] Due to a mix-up Dr. Smith did get one set of his colleagues' records for peer review, and he found a number of substantial errors by them.

hopes that this court will make this a significant focus of its concern for the general benefit of health care in America.

B. The Typical Organization of Medical Staffs

It may be helpful for the court to understand that generally hospital staffs are organized on a departmental basis determined by the nature of the specific care rendered by the doctors. The chair of each department is by reason of that status a member of an executive committee of all the doctors. This group is led by the chief of the medical staff. The natural impulse of such a ruling committee is to support the supplications of component chairmen. If one departmental chief seeks discipline against a member of his department, the other departmental heads tend to go along in the expectation of similar support when they seek a sanction.

Lack of respect for fairness in the review can make one department or a whole hospital a cauldron of abuse in ways that are subtle and not easily relieved until they become so excessive that a public inquiry results.[2] Obviously, the closer all departments in all hospitals adhere to fair standards the less negative impact of abuse affects the public.[3]

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[2] In this case the fully shared system of peer review and careful audits of the orthopaedic and other departments (E.R. 32 to 41 and 374 to 378) stands in contrast to the monopolistic practices of the cardiology and internal medicine departments of the focus hospital.

[3] One example of a double standard in the review is found in the nephrotoxic angiography dye matter. Dr. Smith's competitors called him on the carpet at informal departmental meeting where they claimed he was using harmfully excessive amounts. He returned with the utilization log (kept by cath lab technicians). The log showed the accusers customarily use more than the most Dr. Smith used. That ended the incident. The overusers were not criticized (E.R. 371).
A similar technicians' log of complications in the cath lab (E.R. 28 to 31) was copied by Dr. Smith because it shows his extremely low incidence compared to the accusers. Dr. Marcus testified about this at the JRC (E.R. 99, 229 to 259 and 543).

Comparison audits of a particular procedure are the most evenhanded way to evaluate physician outcomes. the technique is easy to apply. A list of problems common to a procedure is duplicated. A random sample of the cases is pulled by the records librarian. Each member of the department enters data from his *pro rata* share of competitors' charts, and the audit sheets are then combined by the secretarial staff. Sample audit reports from the focus hospital's orthopaedic department are at E.R. 21, 33 to 41 and 357 to 361.

C. The Legal Issue is Not Whether Dr. Smith Practices Good Medicine

UAPD recognizes the reluctance of courts to second-guess professional evaluations among peers. Sophisticated experts can argue the subtle points of patient care in symposia which will boggle even medical professionals.[4] For this reasons, UAPD urges the court to concentrate on the quality and fairness of the procedure rendered in the peer review and hearing process. It is in this realm of due process (fair procedure) that the court is best qualified by training and experience to articulate standards. UAPD is sensitive to the efforts of respondents to raise the specter that Dr. Smith is a bad doctor in an effort to befuddle the issues of fair procedure. They obviously persuaded the Court of Appeals which then short-circuited all the procedural components of the HCQIA. In reviewing the medical cases that court overlooked

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[4] In April, 1993 *Circulation*, a journal published by the American Heart Association, reported that the death rate for women (such as L.W.) having angioplasty is ten times greater than that of men. The significance of such studies to the comparison of Dr. Nagel's death case (of his walk-in patient – a man who died when catheterized inappropriately while in congestive heart failure) with the L.W. case is an issue which may be significant at trial in this matter. Another comparison worth considering is the average 31% rate of physician-caused injury to ICU patients. (See *Crit. Care Med.* Jan. 1993, 440-50). Compare the averages to the few grievances at the focus hospital where Dr. Smith had 1800 patient admissions during his six years on the staff.

Dr. Smith's high level of referrals from other doctors – a factor that points to good quality of care and his extremely low rate of complications in heart catheterization – about one-fifth compared to the average 1% (*Am. J. Surg.* Apr. 1994 375-8). The UAPD is not aware of any of the Informed Consent forms legally required in California before surgical intervention that do not indicate cardiac catheterization is a hazardous procedure with multiple potential severe complications, including death. Contrary to the accusations of substandard care, which the UAPD believes to be a diversionary subterfuge, the 1800 cases cared for by Dr. Smith, with a demonstrated low complication and death rate, strongly supports the notion of Dr. Smith's exemplary practice. Whether Dr. Smith's care was anything but appropriate in the cases cited has never been examined in an antiseptic venue under neutral instruments like those of the justice system. Certainly a procedure as flawed as Dr. Smith has demonstrated here with suppressed exculpatory evidence, a biased fact-finder, an upside-down burden of proof, and a hearing committee under the guidance of a competitor's cousin cannot be accepted as an adequate forum to judge his work.

D. The Effect of Expulsion on an Individual Physician

The loss of practice rights ("privileges") for a single procedure (or greater losses such as illustrated here – total expulsion from a hospital staff) is reported to various registries. Pursuant to 42 U.S.C. § 11133(a)(1) there is the National Registry. A registry is kept by the Federation of State Medical Boards. Additionally, there are state registries (California Business and Professions Code § 803). Records are also kept by medical malpractice insurers. All hospitals consult these registries (as illustrated here by the Good Samaritan references to O'Connor Hospital cases). The career impact of loss of any practice rights is a stain which can never

be washed away.[5] Expulsion from a staff and subsequent registration affects a professional's potential for relocation to another state. Improper use of this system impacts the citizen's right to freedom of movement between the states.

Like defamation, an adverse peer review follows like a shadow. An unjust sanction is a life-long nationwide curse. Certainly the gravity of such a loss necessitates the imposition of maximum procedural safeguards.

E. There is No Standard for Imposition of Sanctions

UAPD's observation of the data derived from cases where restrictions and expulsions have been protested indicates that a large component of those cases reflect unfair imposition of sanctions and a tremendous disparity of sanctions when measured against uniform standards of performance.

The absence of detailed federal peer review and hearing standards is an invitation to spurious accusations. The medical staff structure of the thousands of isolated little hospitals scattered throughout the country which often provide the only service for some procedures within reasonable travel distances creates little local monopolies. The potential for abuse is obvious.

While there are no systematically-gathered statistics, anecdotal evidence reported to UAPD indicates that unfair peer review has not been ended by the HCQIA. In view of UAPD's specific services to its members in peer review matters its receipt of such information is significant evidence that peer review abuse is becoming more common as medicine moves to the ultra competitive environment of managed care.

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[5] Compare criminal law procedures to expunge the record for convicts whose offenses have been expiated. "Expungement of Adjudication Records" 1966 Wash. U.L.Q. 147.

III. SUMMARY OF THE ARGUMENT

Ethical peer review serves the public health interest of society and protects the vested property interest of physicians in their practice rights at the hospital against monopolists. Thorough ethical peer review is a public health necessity; corrupted peer review is a public health detriment.

A structure of ethical peer review requirements and mechanisms for fair hearings and appeals is indicated by the HCQIA but not fully expressed by Congress which intentionally left that job to the Secretary of HHS who declined.

The industry responded with practical guides written by lawyers expert in the field. Most noteworthy is the American Hospital Association's Task Group report because it reflects the views of the very conservative interests who recognize the need for a level of due process which commands respect because it is obviously decent.

Smith rejects these guides as "irrelevant" (footnote 8). In so doing *Smith* presents an extreme departure from the legal history of peer review, the expressed legislative purpose, and the specific language of the HCQIA, especially § 11,112(b)(3).

Smith relied on medical faults alleged by competitors and untested, uncredentialed people. Favorable medical evaluations by Dr. Marcus, a renowned expert, and Dr. Fletcher, a university faculty member, were rejected. This was not justified. Reasonable arguments raised on appeal were condemned as "frivolous."

The opinion below misinterprets the statute and immunizes unfair peer review.

IV. ARGUMENT

A. Highlights of Peer Review Law Before HCQIA

The physician's right to practice his profession in a hospital is central to his livelihood. Control over this valuable right resides in the medical staff organization. The grant and removal of practice rights including the variety of services the

physician is permitted to perform has not been subject to universal standards of fairness.

Most states declined to regulate these rights through legislation before New York enacted Public Health Law § 2801-b in 1972, and few have tried since. (Exceptions include Colorado, New Jersey, Ohio, Pennsylvania, Virginia and Washington. Former Texas Rev.Civ.Stat.Ann. art. 4437f, section 17(c), a 1987 Texas statute which required "procedural due process" for each applicant for medical staff membership, was repealed in 1989.)

For this reason, in the past when disputes over practice rights were fought in the courts great deference was paid to the establishment physicians and scant concern was given to the impact on the public of the system which permits cartelization of hospital medicine. For example, in Illinois, judicial review of private hospital decisions to terminate or curtail existing medical staff privileges was limited by the "rule of non-review" except to determining whether such decisions were rendered in compliance with the hospital's own bylaws. *See Pulido v. St. Joseph Memorial Hosp.*, 547 N.E.2d 1383, 1388 (1989).

In general, judicial review of the denial or curtailment of hospital staff privileges was limited to whether the hospital's decision was made in good faith and on objectively reasonable grounds, whether it was consistent with the public interest, and whether it was supported by sufficient evidence, reasonably related to patient care, in furtherance of a legitimate health-care objective, and not susceptible of arbitrary or discriminatory application. *Pinsker v. Pacific Coast Society of Orthodontists*, 12 Cal.App.3d 541, 116 Cal.Rptr. 245 (1974); see also *Woodbury v. McKinnon*, 447 F.2d 839, 842 (5th Cir. 1971).

However, traditional limited review does not reach a hospital's internal review, trial, and appeal proceedings.

Unfair review has long been recognized as a problem in hospital staff court cases. The California Supreme Court seventeen years ago in *Westlake Community Hospital v. Superior Court*, 17 Cal.3d 465, 484, 131 Cal.Rptr. 90 (1976) observed:

> Our court has long recognized, of course, that the existence of unrestrained authority in hospital boards or professional associations has at times enveloped an arbitrary selectivity that threatened to convert the operating room into the province of an elite clique.

In an *amicus* brief filed on August 15, 1962 in *Willis v. Santa Ana Community Hospital,* 58 Cal.2d 650, 26 Cal.Rptr. 640 (C.A. #268990 at p.21) (1962), the California Medical Association and the California Hospital Association admitted, as emphasized below, that the system of peer review is abused by making malicious accusations against the individual physician:

> Not only do the activities of the organized medical staff of a hospital constitute restraints on competition, but occasionally the activities are carried out for the specified purpose of prohibiting the practice of medicine by one physician. Furthermore, the motivating force behind such action occasionally involves concerted efforts on the part of the members of the committee, or staff, to limit or eliminate the hospital practice of the physician or to create such an economic hardship on the part of the physician that continued practice in the area would be impossible. The aforesaid activities can be carried out with good faith on the part of the members of the staff, yet *acting with malice toward the individual physician* whose conduct is reflecting on standards of patient care or the confidence of the public in the practice of medicine.

The Court of Appeals dissenting opinion, later vindicated by this court, in *Arizona v. Maricopa,* 643 F.2d 553, 565 (9th Cir. 1980); rev. 457 U.S. 332 (1982) noted:

> The health care industry currently does not display significant competitive conditions. . . . It is also undoubtedly true that a major factor has been the active suppression of competition by traditional medical associations. The restraints fostered by

these groups are and should be subject to conventional antitrust scrutiny.

During the last few decades the cost of health care continued to increase as a portion of the domestic product while this medical staff system remained not scrutinized by Congress until 1986 when the Health Care Quality Improvement Act was passed.

HCQIA revitalized the anti-trust judicial remedy while at the same time it tempered access to the courts by establishing an anti-trust immunity and a fee shifting provision to stick the unsuccessful physician litigant with his adversaries' legal fees if the suit is found to be "frivolous, unreasonable, without foundation, or in bad faith." (42 U.S.C. § 11113)

HCQIA immunity is easy to claim because the Act includes a presumption that any medical staff action was done in furtherance of quality healthcare. 42 U.S.C. § 11112 says, "A professional review action shall be presumed to have met the preceding standards . . . unless the presumption is rebutted by a preponderance of the evidence." In interpreting the fair review rules as well as the in-hospital hearing and appeal provisions of 42 U.S.C. § 11112 this court has a clear slate to write upon. The few cases decided heretofore do not address the adequacy of these procedures as practiced in the industry nor do they refer to guides issued by concerned professional associations. References to California's opt-out statute, Business and Professions Code § 809 are also sparse.

What is meant by the words "fair," "reasonable" and "adequate" as used in 42 U.S.C. § 11112 to set standards for the review and hearing process? These have not been defined by the Secretary of Health and Human Services despite Congress' invitation at § 11114. For this reason a review of the constitutional due process cases is a useful start. *Morrissey v. Brewer*, 408 U.S. 471, 481, 92 S.Ct. 2593, 2600, 33 L.Ed.2d 484 (1974) asks the question, "What process is due?" The answer is dictated by the nature of the rights at issue and the surrounding matrix of procedure and law found in the industry.

In *Morrissey,* this court elaborated on the due process requirements by applying the "balancing of interests" test it had first articulated in *Goldberg v. Kelly*, 397 U.S. 254 (1970) determining what procedure is due by weighing the importance of the private interest to be protected against the benefit of summary adjudication.

Whether the Constitution requires that a particular right obtain in a specific proceeding depends upon a "complexity of factors." *Hannah v. Larche,* 363 U.S. 420, 442, 80 S.Ct. 1502, 1515, 4 L.Ed.2d 1307 (1960). In determining whether a particular protection is required, three factors are generally considered:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administration burdens that the additional or substitute procedural requirements would entail.

Matthews v. Eldridge, 424 U.S. 319, 335; 96 S.Ct. 893, 903; 47 L.Ed.2d 18 (1976).

When a physician, particularly a specialist, is expelled from a hospital staff he suffers a number of substantial losses: his referral pattern from doctors in the hospital is ended, his malpractice insurance may become more expensive or be cancelled, other hospitals may decide to expel him (as was done here using the stale cases from O'Connor Hospital) the registries at the state and federal level keep a record of the expulsion,[6] and the state medical board may initiate a procedure leading to license revocation. Obviously, the gravity of these losses to a physician facing expulsion from a hospital staff weigh toward a process which provides substantial safeguards. (See *Matthews v. Eldridge, supra.*)

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[6] Which California law now opens to the public.

UAPD is familiar with many administrative hearing mechanisms for the resolution of disputes[7] and finds that of greatest concern is the impartiality and disinterested neutrality of all decision makers. The record in this case presents undisputed evidence that there was a clear lack of neutrality at the hearing before the hospital Board of Directors, and the previous JRC hearing is flawed by Mr. Bartel's refusal to permit *voir dire* examination of the panel members on the issue of their personal as well as business relations with the accusers. Failure to have *voir dire* was criticized by this court in *Patrick v. Burget,* 486 U.S. 94 (1988).

Neither Mr. Bartel nor Mr. Simmonds conducted their hearings in a satisfactory manner.

Most noteworthy among the numerous deficiencies identified by Dr. Smith are the absence of professional cross-examination by a trained lawyer, the refusal by Mr. Bartel to allow *voir dire* and to compel production of the nurse eyewitness' first written report.[8] His failure to make a record of the JRC's deliberations in which he participated and counseled (at least his statements to them explaining the burden of proof, the value of differences of opinion, the inherent bias of

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[7] Consider the elaborate device the Writer's Guild of American uses to validate attribution of credit for movies. Three arbitrators who do not communicate with each other study the facts and report to a guild officer who reports the majority's decision. See *Marino v. Writers' Guild of America,* 992 F.2d 1480 (9th Cir. 1993). Note the right to strike names from the list of available arbitrators, 992 F.2d at 1484. This device ensures the utmost impartiality of the decision maker, unlike the procedure used in Dr. Smith's case. The upside-down burden of proof on Dr. Smith is also troubling. It is contrary to the California Statute § 809. Compare that to the United Nations' "internal justice system," where the "clear and convincing" burden of proof is on the accuser. *New York Times* March 7, 1994 page A6, and note that the Olympic Committee also puts the burden of proof on the accuser. *New York Times* February 11, 1994 page B17.

[8] Compare a prosecutor's duty of disclosure. *Brady v. Maryland,* 373 U.S. 83 (1963)

competitors, the lack of review by independent outside experts, and other issues on which he advised or should have advised) makes it impossible to conduct an intelligent review which HCQIA was designed to guarantee through 42 U.S.C. § 11112(b)(3)(C)(ii) which requires a complete record.

Mr. Simmonds failed to counsel the Directors to avoid the appearance of bias by recusing members in business or social relations with the accusers which discredited their action. He also failed to make a record of his advice during the board's deliberations in violation of 42 U.S.C. § 11112(b)(3)(C)(ii).

Huang v. Board of Directors, 220 Cal.App.3d 1286, 1294, 270 Cal.Rptr. 41, 46 (1990) established that the Directors in expelling plaintiff from the medical staff inappropriately exercised independent judgment to overturn the decision of the judicial Review Committee which retained plaintiff on the staff.

UAPD believes that when a serious hazard is presented by the charges proportionate fair procedure must be given.

While the statute calls on the Secretary of the Department of Health and Human Services to promulgate standards (42 U.S.C. § 11114), none were ever articulated by the Secretary. In the absence of such guidelines the courts are left with the task of defining these terms and evaluating whether the specific facts presented in the cases meet the statutory requirements. This is the Common Law method.

Where will the courts look for guidance?

Prior to HCQIA the UAPD created a hearing standard in its 1981 "Guidelines for Hospital Medical Staff Bylaws." The California Medical Association followed suit in 1984 by publishing its own 'Model Bylaws' for the hospital medical staff. At a 1986 meeting for health industry lawyers a section of the American Bar Association proposed some standards. In June, 1988 the American Medical Association published its guidelines for Peer Review Procedures. December 29, 1989 the Peer Review Immunity Task Group of the American Academy of Hospital Attorneys of the American Hospital Association published its lengthy guide. It contains a letter dated December 2, 1986 from acting Assistant Attorney General Charles F.

Rule, Esq. to counsel for the American Medical Association in which the immunity of HCQIA for "good faith peer review" is expressed along with the warning against "the exceptional circumstance" where the process is "a sham used . . . to restrain competition" – an "anti-trust violation." Some of that guide's suggestions are detailed in footnote 14 of the petition at page 13. In 1991 the California Legislature enacted a detailed statutory code. These materials were found "irrelevant" by the Court of Appeals (at footnote 8 of the opinion). Thus, it rejected the teaching of the great Justice Oliver Wendell Holmes who wrote, "the life of the law has not been logic; it has been experience" by rejecting the experience of the industry.

The models of UAPD, CMA, AMA, AHA, ABA and the California Legislature when taken together provide a guide to contemporary standards of fairness in the review and hearing process. "Peer review which is not conducted fairly results in harm both to patients and healing arts practitioners by limiting access to care." (Calif. Bus. & Prof.Code § 809(a)(4))[9]

Even before HCQIA was enacted case law expressed standards for good faith professional review hearings. There is a good outline in *Hoberman v. Lock Haven Hospital*, 377 F.Supp. 1178 (M.D. Pa. 1974) at 1188. Also see *Hackethal v. CMA*, 138 Cal.App.3d 435, 441-444, 187 Cal.Rptr. 811 (1982).

B. The Fair Review Requirement Under HCQIA Was Not Satisfied

HCQIA requires a fair review. The legislative history of HCQIA indicates its objective to protect ethical peer review conducted under standards which decent people will respect so that "physicians receive fair and unbiased review to protect

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[9] Concerning protection of a variety of reasonable medical theories see *People v. Privitera*, 74 Cal.App.3d 936, 141 Cal.Rptr. 764, 774 (1977), hearing granted Jan. 5, 1978, 23 Cal.3d 697, 153 Cal.Rptr. 431, cert. denied, 444 U.S. 949 (1979) and *Mt. Sinai Hosp. v. Zoreh*, 271 N.Y.S. 2d 1012 (1966).

their reputation and medical practices." (1986 Code Cong. & Admin. News at 6393.)

Its sponsors made it clear that the review which is protected does not shield "improper anti-competitive behavior from redress." (H.R. Rep. No. 903, 99th Cong. reprinted in 1986 U.S. Code Cong. & Admin. News 6287, 6386.) Rep. Wyden stated: "There is one thing this bill will not do. It will not shield doctors from liability for what are truly anti-competitive business practices." 132 Cong. Rec. H9957 (daily ed. Oct. 14, 1986). Rep. Waxman stated: "The immunity provisions have been restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care. Actions that violate civil rights laws or actions that are really taken for anti-competitive purposes will not be protected under this bill." Id. at H9959. *Wei v. Bodner*, 127 F.R.D. 91, 99 (1989) affirms these concepts.

In accord with this standard and to ensure a fair and unbiased review, the physician should be compared to all other practitioners who do similar procedures if the first HCQIA test is to be met. Unless the worst practitioner in the hospital is the object of a privileges limitation or expulsion what meaning can there be to the test that action must be taken in the reasonable belief that it was in the furtherance of quality care? It is no answer to focus on one doctor. There are few physicians whose hospital work can withstand a super-critical review. It is only by comparison of the group that quality care can be assured. This point was inferred by Joseph A. Califano, Jr., a former Secretary of Health, Education and Welfare, in his *America's Health Care Revolution*, Random House, 1968 at page 91, and at 199 he says regarding outcome data of hospitals, "Comparable [comparison] information should be made available on doctor's performances."

Memorial Hospital v. Shadur, 664 F.2d 1058 (1981) and *Robinson v. Magovern*, 83 F.R.D. 79 (W.D. Pa. 1979) and *University of Pennsylvania v. EEOC*, 493 U.S. 182, 201, 110 S.Ct. 577, 588 (1990) focus discussion on comparison of performance to justify peer review decisions. Also see *Teasdale v. Marin General Hospital*, 138 F.R.D. 691 (N.D. Cal. 1991) and *Wei v. Bodner*, 127 F.R.D. 91, 99 (D.N.J. 1989).

In *Smith* the magistrate judge ordered such comparison of the doctors doing similar work. The Court of Appeals overlooked this tool for determining if HCQIA's requirement that the interest in quality health care was met, nevertheless, the Court of Appeals relied on this specific element of the HCQIA and overlooked the procedural requirements of the act.

It is customary in the review stage for a non-competitive outside consultant to be engaged to assist in putting the review on an unbiased track. (42 U.S.C. § 11112(b)(3)(A)(iii)) Notice that most of the published cases after HCQIA make reference to an impartial outside review of the claims regarding poor medical care. Here outside review requested by Dr. Smith was refused, and only Dr. Smith's competitors testified against him. The alleged problems in the stale old O'Connor Hospital claims were found by Dr. Smith's competitors to have not been present in the 1800 cases he managed at Good Samaritan Hospital – which is why they reappointed him to the staff ten days after the L.W. death.

Once charges are formalized and a hearing is demanded, detailed "discovery" of records will establish the defense that the accused physician is not the worst doctor doing what he does. Mortality and morbidity data is routinely gathered by the hospital organizations. These records are useful in such a defense.

No process which denies its victim access to the records needed to prove his defense can meet the test of procedural fairness. Historically, discovery was provided. *Garrow v. Elizabeth General Hospital, Inc.*, 401 A.2d 533, 541-2 (N.J. 1979) requires that in matters of this kind the accused is entitled to pre-hearing receipt of "relevant and material" information in the organization's possession. Cases in accord are *Hackethal v. Loma Linda*, 91 Cal.App.3d 59, 153 Cal.Rptr. 783 (1979); and *Memorial Hospital v. Shadur*, 664 F.2d 1058 (1981) which proclaims at 1061:

> *[B]ecause evidentiary privileges operate to exclude relevant evidence and thereby block the judicial fact-finding function, they are not favored and,*

where recognized, must be narrowly construed. (Emphasis added.)

In the *Memorial Hospital* case the court ordered production of the records of other doctors to deal with a claim that there was a lack of evenhandedness in the ways various doctors were treated.

In *Suckle v. Madison General Hospital*, 362 F.Supp. 1196 (W.D. Wis. 1973), the court found, *inter alia,* that the member subject to expulsion was entitled to comparison data out of the organization's records. Discovery is a component of the California Statute (§ 809.2) including information sought to defend the charge.

Minimum due process mandates notice, hearing, and an impartial trier of facts. Many state court opinions rest on this court's requirement of an impartial fact-finder as exemplified by *Withrow v. Larkin*, 421 U.S. 35 (1975). California cases which require *voir dire* of the Judicial Review Committee or a like fact-finder are *Appelbaum v. Barton Memorial Hosp.*, 86 Cal.App.3d 648, 657 (1980), *Lasko v. Valley Presbyterian Hosp.*, 180 Cal.App.3d 519, 528-530, 225 Cal.Rptr. 603 (1989); *Hackethal v. CMA,* 138 Cal.App.3d 435, 441, 443; and *Rosenblit v. Superior Court,* 231 Cal.App.3d 1434 (1991), and the cases cited therein. These cases reiterate that most important component of fair procedure – an impartial fact-finder.

Procedural rights found in hospital bylaws have been enforced on the basis that the bylaws themselves may create a contract between the hospital and its staff. (See 41 C.J.S., Hospitals §§ 16, 19; "Procedural Due Process Requirements in Hospital Medical Staff Decisions," 49 T.B.J. 981)

At the hearing, the physical has the right to representation by counsel and to call, examine and cross-examine witnesses. *Hutsville Memorial Hosp. v. Ernst,* 763 S.W.2d 856 (Tex.App. 1988), *Garrow, supra.* In *Smith,* a mute lawyer was approved, which is apparently contrary to the HCQIA.

The trial of an in-the-hospital staff rights case is conducted before a jury of physicians. That committee must be tested by *voir dire* examination under oath to assure that they

are not conflicted by business or personal relationships with the accusers. The same *voir dire* must be conducted of the hearing officer. Section 809.2(c) of the California Business and Professions Code provides for "a mutually acceptable arbitrator" among several options – obviously this method is most likely to be fair. Selection of Dr. Nagel's cousin as law officer of the JRC creates a negative inference on the fairness issue. Why did Dr. Smith's competitors do that if they had a good case? It is customary to engage a retired judge for that function to assure impartiality.

The active service of a lawyer is vital. HCQIA provides for it. (§ 11112(b)(3)(C)(i)) If the lawyer is forbidden to examine witnesses the hearing is not adequate. Wigmore identifies professional cross-examinations as a "vital feature" of the Anglo-American system. (5 Wigmore, *Evidence* 1367 p. 29) Further, he finds cross-examination, "beyond doubt the greatest single engine ever invented for the discovery of truth." *Op cit.* This court has expressed its belief that cross-examination is essential to the administration of justice:

> "It is only when the witnesses are present and subject to cross-examination that their credibility and the weight to be given their testimony can be appraised. Trial by affidavit is no substitute for trial by jury which so long has been the hallmark of 'even handed justice'."

Poller v. Columbia Broadcasting System Inc., 368 U.S. 464, 473, 82 S.Ct. 468, 491, 7 L.Ed.2d 458 (1962).

By laws of some medical staffs include a burden of proof upon the physician to establish that the move against him is arbitrary, unreasonable or unsupported by the facts. This is an unfair burden. AMA, CMA and § 809.3(h) of the California Statute place the burden of proof on the accuser. HCQIA is silent on this point.

In the focus hospital the former burden on the accuser was changed to place the burden on the accused. That burden is magnified here by the accused's inability to demand an unbiased review board, and by an accuser's cousin offering legal tutelage to the board. It is also a concern that an eyewitness' first report of a key event was suppressed in the

review process and at the JRC by respondent Nagel's cousin, Mr. Bartel, the law officer.

HCQIA's § 11112(b)(3)(C)(ii). It should include all explanations of the law given to the hearing committee by the law officer. No court can assess the impartiality of the law officer's advice in the absence of a record of that advice.

The industry guides distill these cases into a practical framework. The AHA Task Group designed its report to be directly responsive to the HCQIA. This court could feel comfortable supporting that responsible organization's suggestions. It is surprising that the Court of Appeals found such guides "irrelevant." More surprising is its approval of an obviously unfair system.

CONCLUSION

UAPD's review of the facts in this case reveals a deeply flawed peer review followed by a hearing and appeal process not worthy of the name.

Monopolists protect their poor medical practices by excluding competitors like Dr. Smith from the ongoing departmental review of all cases. Refusal to perform comparison audits of common procedures according to standardized audit criteria uniformly applied is evidence of conspiracy and a threat to public health.

Strong overtones of conspiracy to monopolize use of a hospital built with public funds inspires a sense of moral outrage and contradicts the legislative intent in enacting HCQIA.

Congress designed HCQIA to eliminate abusive peer review. The system which is conceived to protect patients and the rights of healthcare professionals has in this instance apparently been used to protect and extend the monopolistic interests of Dr. Smith's competitors. The Court of Appeals misinterpreted the HCQIA and turned it into a license for unethical peer review.

Certiorari should be granted.

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